REIMBURSEMENT METHODS FOR STATE-OPERATED FACILITES

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.0307 Reimbursement Methods for State-Operated Facilities

(a) A certified State-operated ICF-MR facility is reimbursed for the reasonable costs the are necessary to efficiently meet the needs of its clients and to comply with federal and state laws and regulations. payments shall be suspended if annual reports are not filed. The Division of Medical Assistance may extend the deadline for filing the report if in its view good cause exists for the delay. The reasonableness and allowability of costs incurred by state-operated facilities shall be determined by the Division of Medical Assistance.

(b) A per diem rate based on the provider's estimated annual cost divided by patient days shall be used to make interim payments. A tentative settlement shall be issued based on the desk audit performed on each annual cost report to determine the amount of Medicaid reasonable cost and the amount of interim payments received by the provider.

(c) Any payments in excess of costs shall be refunded to the Division of Medical Assistance. Any reasonable costs in excess of payments shall be paid to the provider. An annual field audit may be performed by a qualified independent auditor to determine the final settlement amounts.

RATE APPEALS

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.0308 RATE APPEALS

(a) The Division of Medical Assistance shall consider only the following appeals for adjustment to the rates which would result in an annual rate increase to the provider from the Medicaid Program of one thousand dollars ($1,000) or more.

(1) Appeals because of changes in the information used to calculate a facility's prospective rate.

(2) Appeals for significant increases or decreases in a facility's overall base period operating costs due to, but not limited to, implementation of new programs, changes in staff or service, changes in the characteristics or number of clients, changes in a financing agreement, capital renovations, expansions or replacements which have been either mandated or approved by the Division of Medical Assistance and, except in life-threatening situations, approved in advance by the applicable State agencies.

(3) In order for said changes to be considered, they shall be consistent with all of the provisions of this plan.

(4) Upon proper notification to the provider in writing, the Division of Medical Assistance may instigate a proceeding to reduce the provider's rates. A rate reduction proceeding may be initiated upon the determination of just cause by the Division of Medical Assistance. Grounds for just cause may include, but are not limited to, the following:

(A) The provider has achieved material over-collections of Medicaid funds derived from the prospective rate being greater than reasonable Medicaid costs.

(B) Changes in Federal or State laws or regulations resulting in material operational cost savings.

(C) Material changes in client profile resulting in the need for less costly services.

(D) The burden of proof shall be on the Division of Medical Assistance to prove the need for said rate reduction.

(5) In determining a fair and reasonable rate under appeal, the Division of Medical Assistance shall take into consideration all funds available to the provider from the Medicaid program and patient liability. Providers are expected to utilize all available funds to provide the services that their clients need.

(6) Reasonable occupancy factors, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances, shall be utilized in establishing fair and reasonable rates in the appeal process.

(7) The Division of Medical Assistance shall not pay interest on the final dollar settlement resulting from the retroactive impact of any rate appeals.

(b) Notification of appeal:

(1) In order to appeal a rate the facility shall send to the Division of Medical Assistance an appeal application in writing within 60 days subsequent to the proposed effective date of the appeal rate.

(2) The appeal application shall set forth the basis for the appeal and the issues of fact. Appropriate documentation shall accompany the application and the Division of Medical Assistance may request in writing such additional documentation as it deems necessary.

(c) The burden of proof on appeal shall be on the facility to present clear and convincing evidence to demonstrate the rate requested in the appeal is necessary to ensure efficient and economical operation, and meets the criteria of this State Plan.

(d) There shall be written notification by the Division of Medical Assistance of the final decision on the facility's rate appeal. However, at no point in the appeal process shall the facility have a right to an interim report of any determinations made by any of the parties to the appeal.

AUDITS

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.0309 AUDITS

(a) Each facility shall maintain the statistical and financial records which formed the basis of the reports required by this plan and submitted to the Division of Medical Assistance for five years from the date on which the reports were submitted or due, whichever is later, or for such longer periods as may be required under State or Federal law. Each cost report shall be verified by the state agency or its representative for completeness, accuracy, and reasonableness through a desk audit. Field audits shall be performed as required. When a combined cost report is filed under this plan, only the combined cost report is subject to desk and field audit, unless the Division of Medical Assistance determines that the supporting individual facility cost reports need to be audited.

(b) All such records shall be subject to audit for a period of five years from the later of the date on which all required reports were filed with the Division of Medical Assistance or the date on which such reports were due.

(1) Desk or field audits shall be conducted by the Division of Medical Assistance, its designated contract auditors, or other governmental agencies at a time and place and in a manner determined by said governmental agencies.

(2) The audits may be performed on any financial or statistical records required to be maintained.

(3) Any findings of an above-described audit shall constitute grounds for recoupment at the discretion of the Division of Medical Assistance, provided that such audit finding relates to the allowable costs.

(c) All filed cost reports shall be desk audited and tentative settlements made in accordance with the provisions of this plan. This settlement is issued within 180 days of the date the cost report was filed or within 272 days of the end of the June 30 fiscal year reflected in the cost report, whichever is later. The state may elect to perform field audits on any filed cost reports within three years of the date of filing and issue a final settlement on a time schedule that conforms to Federal law and regulation. If the state decides not to field audit a facility a final reimbursement notice may be issued based on the desk audited settlement. The state may reopen and field audit any cost report after the final settlement notice in order to comply with Federal law and regulation or to enforce laws and regulations prohibiting abuse of the Medicaid Program and particularly the provisions of this reimbursement plan.